Article

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Approximately 90 per cent of women in the UK who have a vaginal birth experience some degree of perineal trauma (Royal College of Obstetricians and Gynaecologists [RCOG] 2015). Recent studies have noted that perineal trauma and extensive perineal trauma rates are rising in developed countries (Dahlen et al 2015). For this reason, it is imperative that midwives and other health care professionals working within the maternity services are aware of how to support women who are at an increased risk of sustaining perineal trauma during birth. Many women experience postnatal mental health issues due to perineal trauma. These effects can have consequences on women's everyday lives and implications for their families. With the complex physical and psychological effects of perineal trauma, it is important for midwives to be aware of these issues and know how to support women, linking with members of the multidisciplinary team when needed (Priddis et al 2012).

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INTRODUCTION

Reducing the risk of perineal trauma and providing effective care following perineal trauma during birth are important topics for childbearing women and should remain high priority for midwives and other health care professionals (Dahlen et al 2015). With the rates of perineal trauma increasing in the UK, identification of women who are at increased risk, particularly of severe perineal trauma, remains a priority. The long-term consequences of perineal trauma can be debilitating and can also affect a woman's emotional health and day-to-day quality of life (RCOG 2015). Kettle and Tohill (2008) and Richmond (2014) report that many women continue to have long-term perineal pain following perineal trauma, with some experiencing dyspareunia, urinary problems or faecal incontinence. Although there is no way to completely remove the risk of perineal trauma, understanding how we can reduce the incidence can have a positive impact on the care offered by midwives. Severe perineal trauma can affect many aspects of a woman's life longer term,

including her physical and mental health, as well as future pregnancies. In the short term, there can be problems with looking after a newborn while recovering following birth; in the long term, women may feel that they cannot go through a vaginal birth again, perhaps contributing to a rising caesarean section rate.

RISK FACTORS

Over recent years, there has been a rise in the number of women giving birth with a range of complex needs that may put them at risk of sustaining perineal trauma at birth (RCOG 2015). Although evidence and guidance demonstrate an increase in perineal trauma rates, it should also be considered that standardised classification of perineal tears and better training of health care professionals in recognising trauma, may contribute to this increased rate. Health care professionals should consider that perineal trauma is not always an indicator of poor care. Birth-associated perineal trauma affects many women, and correct assessment of trauma and effective repair are crucial clinical skills (Macdonald 2013). Education for health care professionals and training in repair of perineal trauma have improved over recent years, with the introduction of more online modules, eLearn packages and increased training among NHS trusts.

ADVICE AND INFORMATION

Antenatal risk factors for increased risk of perineal trauma also include primiparity, maternal age, nutritional status, previous perineal trauma, larger fetal weight and a shorter perineal body. All women, regardless of whether or not they are at increased risk of perineal trauma, should be offered information about perineal trauma, together with the evidence and research surrounding perineal wound care in the postnatal period. As midwives and health care professionals, we have a duty to discuss this important matter with women and also to support women who have experienced perineal trauma. However, with so many other issues to discuss with women during pregnancy, perineal trauma can often be a subject that receives very little time or discussion. However, consideration should be given to the physical and psychological effects of perineal trauma and, with this in mind, midwives should put aside time to discuss this important issue with women.

Antenatal advice about perineal trauma and caring for perineal wounds should be offered to all women, regardless of the risk of sustaining perineal trauma. Often, a written information leaflet is useful to give to women in the antenatal period. Although education in an antenatal-class setting might be beneficial for some women, Nolan (2009) discusses how women often report ‘information overload’. Verbal information is useful for women as it gives the midwife the opportunity to interact with women; however, written information can also be used to support the verbal discussion. Effective communication and language barriers should also be explored by health care professionals, with consideration for women who may not be able effectively to communicate (Brandie and MacKenzie 2009). Good communication and compassionate care are needed to support all women, but particularly to support women at increased risk of experiencing perineal trauma (Dahlen et al 2015).

Antenatal perineal massage is known to reduce the need for episiotomy prior to birth and has been shown to reduce postnatal perineal pain (Beckman and Garrett 2006). Women who have not had a previous vaginal birth, should be informed of the benefits of antenatal perineal massage. Women should be recommended to carry out perineal massage from 35 weeks of pregnancy, with a supportive discussion that perineal massage could reduce the likelihood of perineal trauma and ongoing perineal pain (Beckman and Stock 2013). The impact of antenatal perineal massage is clear for women who have not had a previous vaginal birth, but is less clear for multigravida women, but there do not appear to be any adverse effects for women using antenatal perineal massage.

INTRAPARTUM CARE

The National Institute for Health and Care Excellence (NICE) (2014) has offered guidelines when caring for women during labour and birth. Practices such as perineal massage in the second stage of labour are not recommended by NICE; however, either the 'hands on' or the 'hands poised’ technique can be used to facilitate spontaneous birth (NICE 2014). Until there is conclusive evidence, the choice of the hands-on or hands-poised technique should ultimately be determined by the clinical judgement of the individual midwife and the wishes of the woman at the time of birth (Petrocnik and Marshall 2015). Evidence has shown the benefits of offering women warm compresses in the second stage of labour. This evidence has demonstrated a decrease in the incidence of perineal trauma when a warm compress is used in labour and this practice appears to be well accepted by women and midwives; therefore this practice could be offered to women during the second stage of labour (Aasheim et al 2011).

There is differing guidance regarding the use of the birthing pool and birthing stool when considering reducing perineal trauma. Evidence has demonstrated that women giving birth in water have been shown to have a decreased incidence of perineal trauma when compared with women giving birth on a birthing stool (Dahlen et al 2015). However, not all women wish to give birth in the water, so the wishes and wellbeing of the woman should be considered within the birth setting. Due to the complex needs of some women, the obstetric-led birth setting may be the recommended place of birth for some women. Women giving birth within this setting may be subject to a cascade of intervention. It should be remembered that intervention in birth starts a cascade that increases the risk of perineal trauma (induction of labour, epidural analgesia and instrumental birth). When possible, normal physiological birth and models of care that reduce intervention and support the wishes of women, should be promoted to women and need to be utilised in all care settings, where appropriate (Dahlen et al 2015).

FOLLOWING BIRTH

Women often report anxieties around suturing the perineum following birth, the most common anxieties being about a delay in suturing

and the associated discomfort (Royal College of Midwives (RCM) 2012). Midwives should be mindful of the language that they use and their actions during suturing and the postnatal period to avoid causing unnecessary distress (Priddis et al 2012). All health care professionals should remember that care, kindness and compassion can make a difference to women at this traumatic time. Analgesia following perineal trauma is an important issue and can make a difference to women, enabling them to effectively mobilise and care for their new baby. In a study exploring the use of ice as analgesia for perineal pain, East et al (2012) noted that women reported less pain after giving birth when they used perineal ice packs, compared to women using no treatment. Whichever method of analgesia a woman chooses to use, she should be offered adequate information to enable her to make an informed choice. A management plan should be developed, with the woman, to ensure that she is aware of the options following birth and of how to ask for help and support, if needed. The underpinning philosophy of care for the postnatal period should encapsulate a holistic approach, where physical symptoms of perineal pain and discomfort experienced by women are not tackled in isolation from any psychosocial impact this may also have (Way 2012).

Recently, there has been much media coverage about the psychological effects of perineal trauma after birth (Mackenzie 2016). Women may be poorly prepared for the impact that perineal pain and discomfort can have on their lives. Consideration should be given to finding different ways of communicating these issues to women in the early postnatal period. Reassurance should be given, with advice and contact information for further support if needed. Women should be encouraged to talk about their concerns and discuss their anxieties about perineal trauma. Often women will feel embarrassed about discussing perineal care and wound healing, yet midwives can alleviate these fears by discussing these important issues with women. Doing so allows women to understand that they are not alone in their concerns and that it is acceptable to speak about any issues they may have.

CONCLUSION

Women who are at risk of, or who have sustained perineal trauma, should be supported by midwives and other health care professionals with kindness, care and compassion. Women should be offered information in the antenatal and postnatal period about the risks of perineal trauma and how to care for their perineum following birth. Midwives can work collaboratively with women and other members of the team to formulate a plan of care that is supportive of the woman's needs and wishes. Working together and supporting women, can decrease anxiety and increase physical and mental wellbeing for the woman and her family.

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